

# Sexually Transmitted Infections

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## Editorials

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### Choosing and using services for sexual health: women's views

As the paper on chlamydia screening by Dixon-Woods *et al* in this issue (p 335) shows, qualitative research can tell you how patients are referred to sexual health services and why they come. These provide compelling reasons for integrating qualitative with more standard quantitative methods in STI research. The control of infection depends not only on effective prevention and treatment of pathogens but also on the interactions between pathogen, host, and environment. Qualitative methodologies are integral to our understanding of at least two points in this triangle. Interview, fieldwork, and a range of other methods allow us to describe what people say and what they do, and to investigate the often complex relationships between the two.

The paper highlights findings from interviews with patients that are relevant to clinical and public health planning. The authors show that patients are “ambassadors” of the services and thus underscore the importance of lay rather than professional networks of referral to services. They demonstrate the importance of being able to phone for results and thus the need for patients to retain an element of control over interactions in the clinic. They show too that consultations are prompted less by concerns about a specific infection and more by a range of symptoms or behavioural cues that could fit with a number of infections, a generic “STI” as it were.

The major objection to qualitative research has generally been one of scale. STI clinic staff and scholars from other traditions may already “know” the findings of studies such as the ones reported in this issue; they seem to be mere common sense. Doctors, for example, already know that the stigma attached to clinics deters potential patients and that the fragmentation of services makes optimal management impossible, for example, in providing contraception alongside STI treatment. On the other hand, qualitative studies often also cause surprise and disbelief. In such situations, findings may be rejected above all for their lack of power: “the numbers were too small.” This problem has been addressed by treating the qualitative as a pilot study leading to larger scale investigations. For example, the relevance of health promotion for a generic, and possibly asymptomatic, STI as suggested by Dixon-Woods *et al* would need testing in a larger population. Yet, larger studies are not always necessary. It should be possible to introduce telephoning for results and then assess the benefits for some or all patients without further research.

A second standard method of dealing with issues of scale is to integrate qualitative and quantitative research more thoroughly. Research on sexuality requires particular sensitivity and large scale surveys have drawn upon initial

contextual studies showing what can sensibly be asked and analysed in terms of what are often called “knowledge, attitudes, beliefs, and practices” (KABP). They have also drawn on subsequent fieldwork and interview to help interpret data.<sup>1</sup> A good example of combined qualitative and quantitative research is found in partner notification for STI. Recent studies in the United States have reported that sexual contact tracing provides a low yield in contrast with social contact tracing, most likely because it is hard to identify and contact all sexual partners on the one hand while, on the other, these partners are found largely among social groups of peers.<sup>2</sup> Research combining qualitative and quantitative techniques inside clinics, through interviews of social/sexual contacts and fieldwork at places where “high risk” individuals congregate has been combined in order to better understand transmission dynamics and design interventions. In research on risks of gonorrhoea, we tested a biological marker for unique sexual networks, differentiating types of gonorrhoea,<sup>3</sup> so as to see whether it would be possible to generalise the results of in-depth interviews and fieldwork through potentially routine clinic data.

In STI research, the qualitative has further connotations. Two of the more important include the settings that are studied and the definitions of health employed. The study of Dixon-Woods and colleagues took place in an STI clinic but many have been conducted outside the clinic and often with marginal and deprived groups, sometimes known as the “hard to reach” or “out of reach” because they do not use health services. Secondly, qualitative research tends to involve a broad social definition of health, compared with a medical view of dysfunction. This may redress current biases towards overly technological understandings and provide more appropriate bases for health promotion as patients may be concerned with one infection only in the context of others, with STI in relation to reproductive health, or with sexual health in relation to general wellbeing. In research on sex work, we have attempted to combine qualitative and quantitative elements over several years so as to build up relationships with a stigmatised social group inside and outside the clinic and develop services considered appropriate by participants, based on this more holistic model of health. In developing a “quantified anthropology” and a “social epidemiology,” we also intended to provide insight into the content and meaning of activities associated with STI alongside objective outcome measures. Accordingly, neither the qualitative nor the quantitative element stands alone. If, for example, 20% of a “high risk” category do not use condoms all the time, it is necessary to

understand when condoms are not used, among whom, and why before it is possible to design a feasible intervention.<sup>4</sup>

It should not be forgotten that the scale of qualitative research is also its strength, enabling an understanding of interactions between host, pathogen, and environment over time and in the context of relevant variables such as relationships with sexual partners and service use. These advantages tend to be lost in studies of large numbers and so it is preferable to employ one of the analytic techniques available for generalising findings about social relationships concerning class, network, sex, and so forth to "scale up" findings of this kind. Further development of these markers will make it possible to achieve greater integration

between complementary studies of the biological and social, the qualitative and the quantitative.

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- 1 Van de Ven P, Aggleton P. What constitutes evidence in HIV/AIDS education? *Health Educ Res* 1999;14:461–71.
- 2 Rothenberg R, Kimbrough L, Lewis-Hardy R, *et al*. Social network methods for endemic foci of syphilis: a pilot project. *Sex Transm Dis* 2000;27:12–18.
- 3 Day S, Ward H, Ison C, *et al*. Sexual networks: the integration of social and genetic data. *Soc Sci Med* 1998;47:1981–92.
- 4 Ward H, Day S, Weber J. Risky business: health and safety in the sex industry over a 9 year period. *Sex Transm Inf* 1999;75:340–3.

*Editor's note:* See also paper by Scoular *et al*, p 340–3.

## Destigmatising STIs: remaining challenges, new opportunities

The potential barriers to attendance at specialist sexually transmitted infection (STI) services have long been recognised. The Royal Commission report in 1916 advised that to be effective, services needed to be "skilled, free . . . and provided at the earliest possible moment." In addition, clinicians needed to be aware of "the fear of disgrace and the consequent desire for concealment" that could hamper treatment delivery.<sup>1</sup> In many respects the UK GUM services have risen to these challenges. The majority of clinics provide timely, effective care from easy to access and well located clinics.<sup>2</sup> We are successful at attracting new referrals and have seen a year on year increase in voluntary attendances with a record 1.5 million consultations in 1999. With this level of success it would be easy to conclude that STI services are both accessible and acceptable for at least the majority of the UK population. However, it would appear that many patients with known or suspected STIs are still reluctant to attend genitourinary medicine (GUM) clinics for care. The principal suspected reason for this is the stigma associated with an STI diagnosis, which may be reinforced by the need for attendance at GUM clinics.<sup>3</sup> In this regard, genitourinary medicine has much in common with mental health and cancer services. However, GUM specialists particularly value open access and strive to provide a confidential, non-judgmental, and supportive service, so it is particularly galling for them that a visit to a GUM clinic should be viewed as stigmatising by many potential users.

In looking at the possible consequences of stigma on health seeking behaviour it is helpful to look at its constituent components. It is generally considered that two elements exist—"felt" stigma, which is determined by an individual's background, education, and personal experiences and "enacted" stigma, the direct consequence of those around them discovering their problem, and resulting in discrimination. The levels of stigma attached to a particular behaviour or illness are not fixed; they vary between cultures and historically. There is some evidence that within modern culture, those conditions, which are to some extent behaviour related, attract most stigma. Importantly though, both felt and enacted stigma are amenable to public education campaigns.<sup>4</sup>

In this issue of *Sexually Transmitted Infections* (p 340) Scoular *et al* examine the experience and evolution of stigma among young women recently diagnosed with chlamydial infections initially outside a GUM setting. This is an important paper because although it is recognised that the stigma associated with GUM clinics is a barrier to

patient access, the question of how modern GUM services can work to modify individuals' experiences of stigma associated with STIs has been largely ignored. Using a qualitative approach with semistructured interviews the authors provide a useful insight into how people feel about being diagnosed with an STI and their experience attending a GUM clinic. These participants had often not disclosed their intended visit to others and fear, isolation, and secrecy pervaded the consultation. Gratifyingly, although a GUM clinic visit was experienced as a stressful event, these study patients did not have their worst fears recognised and some even looked upon it as a positive experience. A process of normalisation and acceptance of information provided by clinic staff resulted in these young women overcoming initial reservations about attending a GUM clinic.

The second important finding of this paper was a comparison of how these individuals viewed GUM services and a family planning clinic (FPC). The GUM clinic was viewed as more "dangerous" than family planning services, which had a more benign appeal. The FPC was valued because it appeared to be associated with a perceived distance from a "disease model" of health care. There was no embarrassment or shame associated with the FPC; however, the GUM clinic was seen as being only attended by individuals who possessed traits that were deemed to be socially and morally unacceptable. It was "normal" for young women to attend an FPC but a GUM clinic existed for "others."

So what are the challenges and tasks for those working in GUM services and those responsible for directing policy? A role of the GUM physician in the education of other healthcare professionals and the general population seems to be a key issue in destigmatising GUM clinics. The respondents in this study had very little knowledge or understanding of STIs and the scale and difficulty of the task should not be underestimated. Previous public health strategies focusing attention on "high risk" individuals have probably intensified the marginalisation and stigma associated with STIs and GUM clinics. Ignorance of STIs and the role of genitourinary medicine are not confined to the lay public and pervade many areas of health care. Many workers in frontline services are reluctant to suggest to their patients that they attend a GUM clinic in case the patient is offended at the inference. The Monks report has gone some way to address stigma by moving clinics from obscure areas of the hospital into the centre of the main hospitals and currently we have unique opportunities to